

APPENDIX OF DICTATION TEMPLATES
Undergraduate Medical Education

Approved by:	Clerkship & Electives Committee
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I. PURPOSE

The following dictation samples are included to provide clinical clerks with guidance.

II. DEFINITIONS

CTU	Clinical Teaching Unit
MRP	Most Responsible Physician
PCCU	Paediatric Critical Care Unit

III. APPENDIX

CTU - Discharge Summary Dictation Template

All patients who 1) were admitted for seven or more days, and/or 2) had been admitted to the PCCU (Paediatric Critical Care Unit), and/or 3) had a complex condition or complicated course in hospital require a dictated (or typed) discharge summary.

- 1. Required initial information:** Your name and position, most responsible physician (MRP) on the day of discharge, patient's first and last name, PIN, who should receive this discharge summary (the MRP, the referring physician if one is known, the paediatrician or family physician of the patient (if not the referring physician), and other consultants who are going to see the patient in follow-up.
Example: "This is John Smith, clinical clerk for Dr. X, dictating on patient Getme Outofhere, PIN 00000000. Please forward copies to Dr. X, Victoria Hospital, Dr. Y, family physician in London, Dr. Z, Paediatrician in London."
- 2. Most responsible diagnosis:** Diagnosis primarily responsible for the patient's current admission.
- 3. History of present illness:** Essential history of chief complaint as given by patient and/or care providers. It should include a concise summary of the relevant information from the time the symptoms started and up to the arrival at the Emergency Department. In children with a chronic disease of the organ system now acutely affected include a one- or two-line summary of the underlying condition. *Do not describe other chronic issues here (see point 4.).*
Example: "Sam X is a 9-month old boy with chronic lung disease secondary to prematurity (27 weeks of gestation) on 0.5l of oxygen at home. He presented to our Emergency Department on July 1, 2010, with a 2-day history of increasing cough, increasing oxygen requirements (from the usual 0.5l to 2l on the day of presentation) and work of breathing, fatigue, and fever up to 38.9°C."

4. Additional problems / relevant past medical history:

List other relevant medical issues not primarily responsible for the admission in brief. For children with multiple and/or chronic medical problems, state health care provider following the child.

Example: “- Prematurity: Born at 27+2 weeks of gestation by spontaneous vaginal delivery, Apgars at 1 and 5 minutes were 2 and 5. The baby had a complex postnatal history including 52 days of mechanical ventilation and a total stay of 13 weeks in the Neonatal Intensive Care Unit. Please see NICU discharge summary for details. Sam’s development is followed by Dr. A, Thames Valley Children Centre London.

- Seizure disorder: Seizures controlled with Phenobarbital, last seizure January 2010, followed by Dr. B, Paediatric Neurology, Victoria Hospital London.”

5. Clinical findings:

State abnormal clinical findings on admission. Negative findings should only be mentioned if clinically relevant to the case.

6. Investigations/Interventions:

List relevant laboratory findings and other relevant investigations and interventions performed.

7. Management in hospital:

Provide a concise summary of the management and course in hospital.

8. Medications:

List current medications on admission and, if applicable state any changes made to them. List all new medications.

Example: Current medications:

- Spironolactone 5 mg po q12h

- Salbutamol MDI, 2 puffs (100 mcg) via Aerochamber q6h (increased from 1 puff via Aerochamber q8h)

New medications:

- Cefuroxime 110 mg po BID

9. Discharge plan and follow-up:

List treatments (include time line) and follow-up (include specifics of appointments).

Example: - Cefuroxime 110 mg po BID until July 8th, 2010

- Follow-up with Dr. Y on Monday, July 12th 2010, at 9:00am

10. Closing:

Example: Thank you very much for your referral.

Pediatric Dictation – New Clinic Visit (Consultation)

- 1) Dictate your name and the name of the MD for whom you are dictating.
- 2) Dictate the name of the MD to which the letter is to be addressed, and the names of any physicians to whom copies of the letter should be sent.
- 3) Dictate a brief introductory paragraph, including the patient’s name, age and the date of the clinic visit. Clearly state the reason the patient was referred for consultation.
- 4) Dictate the body of the note using the following subheadings where applicable:
 - a) History of Present Illness – Detailed history of the presenting problem including any relevant review of systems.
 - b) Past Medical History – Include any relevant medical problems, past admissions and surgeries. Note any consultants who are following the patient. Include medications, drug allergies and immunization history. Provide basic birth history (e.g. gestational age and birth weight) if felt to

be relevant. In a very young infant include a more detailed obstetric and birth history under a separate subheading.

- c) Family History – Include both parents' and all siblings' ages and health status. Provide further history on medical disorders relevant to the subspecialty that are present in the family.
- d) Developmental History – Include any relevant developmental milestones and ages at which they were achieved. Provide any relevant information related to school performance and the grade the patient is attending. Describe any concerns expressed by the parents.
- e) Social History – Include a description of who lives at the patient's home. If relevant, include whether the child attends day care.
- f) Physical Examination – Include height, weight and head circumference if obtained, including percentiles. Include any vital signs obtained on the patient. Dictate information on the examination performed, with particular focus on systems relevant to the subspecialty. Include both pertinent positives and negatives.
- g) Investigations – Include any information on investigations reviewed at the visit or performed on the day of the visit.
- h) Assessment and Plan – Provide a very brief (2-3 sentences) summary of the patient's presentation. Include a diagnosis and differential diagnosis where relevant. Dictate information on plan for further investigation, treatment and follow up the patient.

Psychiatry Initial Assessment Note

Please note that Psychiatry has a standardized form that is used in the emergency department.

Patient Name:

Patient Identification Number (PIN):

Date of Birth:

Visit Date: date and time

Identification: Outline the patient's age, marital status, living arrangement and source of income.

Include referral source, where the patient was assessed and legal status – i.e. If the patient was seen in the emergency department and if they were on a form 1 or 2 at the time.

Presenting complaint: As outlined by the referral source. If the patient is self-referred the presenting complaint should be in the patient's own words.

History of Presenting Illness: The HPI is a complete description of symptoms including onset and duration. The HPI should include both positive and negative findings. As an example if the patient presents with depression you should not only document what neuro-vegetative signs and symptoms they experience but also which functions are spared. You must also document if suicidal or homicidal ideation was present.

The HPI also includes collateral information derived from other sources such as the medical record, case worker or family.

Past Psychiatric History: Include timing, estimated length and location of past admissions. Record past treatments and response to them. Make sure to get history of self-harm and violence to others and record it even if the response is negative. Ask about previous out-patient or general practice treatment. It is very easy to miss past and present counselling/psychotherapy (many people presenting in a crisis seem to omit mentioning this) so ask about it specifically.

Past Medical History: This should include significant illnesses and operations. Ask about previous head injuries and seizures.

Medications: Medication the patient is taking or should be taking, with rough duration.

Allergies:

Substance Use:

- **smoking** (daily amount)
- **alcohol** (date last used, current/past withdrawal symptoms)
- **illicit drug use** (date last used, current/past withdrawal symptoms)
- **OTC medication** used with regularity (i.e. Gravol, cough syrup, Tylenol #1)

Family Psychiatric History: Family history of depression, anxiety, psychosis, substance abuse and completed suicide.

Social History: Should include developmental milestones, education, relevant work history, history of trauma and current supports and stressors. Be sure to ask about legal history including violent behaviour which may not have resulted in a criminal conviction.

Mental Status Examination: The MSE includes the patient's appearance and behaviour during the interview. You must comment on the patient's mood and affect as well as thought form, thought content and speech. Although perception is included in the MSE a complete description of the patient's hallucinations and delusions should be clearly described in the HPI not the MSE. In the MSE you should comment on whether the patient is responding to unseen stimuli. Please also comment on cognition, completing a formal mini mental status examination if necessary. The MSE should also reflect on the patient's insight such as their appreciation of their diagnosis.

DIAGNOSIS:

Axis I: Psychiatric diagnosis (patients can have more than one)
Axis II: Personality disorder and mental retardation - if unsure write deferred, if none write nil
Axis III: Medical conditions
Axis IV: Psychosocial stressors
Axis V: Global Assessment of Functioning

PLAN:

Medication suggestions
Psychotherapeutic interventions
Social interventions (i.e. apply for Ontario Disability Support Program)
Follow-up

Name of person dictating and for whom

Cc: Referral source
Hospital chart (Psychiatry has not completely converted to the electronic patient record)
Attending physician

Psychiatry Progress Note

In Psychiatry the SOAP (Subjective, Objective, Assessment and Plan) format can be used. The SOAP note is a daily progress report in the patient's chart, and so it is different from the comprehensive admission note. In effect it should outline any changes in the patient's symptoms and physical findings. It should also outline the current formulation and plan for the patient. Typically psychiatry progress notes are written as a narrative without the use of SOAP headings other than for Assessment/Impression and Plan.

Clinical Clerk progress note

Date and time patient seen

S: Include events since last assessment including the use of PRN meds and the need for restraints. Review of symptoms – i.e. change in depressive or psychotic symptoms.

O: Should include vitals if relevant.

Mental Status Examination: Remark on the patient's appearance and behaviour during the interview. You must also document the patient's mood and affect as well as thought form, thought content and speech. Include concerns regarding suicidal or homicidal ideation. As part of the MSE comment on the patient's insight and judgement. If there are concerns about cognition always comment on orientation and perform a MMSE if necessary.

Assessment/ Impression: Brief statement of overall impression, including multi-axial diagnosis if appropriate.

Axis I: Primary psychiatric diagnosis

Axis II: Personality disorder and mental retardation.

Axis III: Medical conditions

Axis IV: Psychosocial stressors

Axis V: Global Assessment of Functioning

Plan: Medication suggestions, suggestions for additional consults, or suggestions for placement,

Author's name and clinical status

Psychiatry Discharge Summary

The discharge summary is a very important and useful document. It may be referred to years later and it should be possible to gain a good idea of the patient's mental state and the degree of evidence for the diagnosis reached. It should also provide a record of responses to different therapeutic interventions.

Patient Name:

Patient Identification Number (PIN):

Date of Admission:

Date of Discharge:

Discharge Diagnosis:

Axis I:	Psychiatric diagnosis (patients can have more than one)
Axis II:	Personality disorders and mental retardation – if unsure write deferred, if none write nil
Axis III:	Medical conditions
Axis IV:	Psychosocial stressors
Axis V:	Global Assessment of Functioning (on discharge)

Identifying Data: Outline the patient's age, marital status, living arrangements and source of income.

Circumstances Surrounding Admission: Summarize the circumstances surrounding admission including whether the patient was admitted from the ER or from an outpatient clinic. Indicate if the patient was voluntary or admitted under the Mental Health Act.

Provide a full account of the development of the current episode of illness in chronological order.

Depending on the consultant you may also be asked to include the past psychiatric history, past medical history, family history and social history in your discharge summary. Please see initial assessment note template for details.

Course While in Hospital: The course of the admission should include:

- Investigations performed and results
- Treatment and progress - This is an account of treatment intervention. Other developments during the course of admission should also be described here.
- Mental status at the time of discharge.

Discharge Plan:

- Medication on discharge.
- Follow-up - List appointment times for professionals who will be involved in aftercare.
- Prognosis - A sentence or two about the likely course of future illness, often with a note about the dependence of the prognosis on the patient's compliance with treatment.

Name of person dictating and for whom

Indicate who should receive copies of discharge summary

Medicine - Inpatient Documentation

In this document, you will find the answers to many of your inpatient related documentation questions:

- I. How should I write up my admission notes?
- II. How should I write my follow-up notes?
- III. Special Circumstances (goals of care orders and procedure notes)

I. How should I write-up an Admission Note

Note: The following is meant as a sample only. Individual styles may vary.

I.D.: Mr. X. is a ____y.o. male who lives in London with his wife. He works as a...

Reason for Admission/chief complaint: He was referred by ____ for ____

Active Problem List

List the most important headings on his problem list

Source: include if the source is not the patient or the history does not seem to be reliable

HPI/Active Problems

Use the headings from your active problem list

1. Re: _____

(these headings are not symptom based, they are Problem/System based. i.e. Re Chest pain means: discuss all relevant symptoms pertaining to this differential diagnosis; don't discuss SOB and Chest pain as separate problems unless you think that they are unrelated i.e. Angina and COPD)

-First paragraph (introduction of patient problem up until arrival to see you)

At baseline, he is _____. One week PTA (prior to admission/arrival) he began to develop _____ this subsequently progressed such that _____. He finally presented to hospital

...

-Subsequent paragraph(s)

The rest of the HPI has two purposes:

- 1) Problem Solving: Demonstrate your thinking process with regards to determining the diagnosis and ruling out alternative diagnoses. This would include describing the symptoms in details and elaborating on pertinent +ve and -ve risk factors.
- 2) Decision Making: Once you have an idea of what is the likely diagnosis, you may need further information to help you determine how to manage the patient (i.e. Severity/prognosis, risk modification, improve symptoms (effect on function), decisions regarding further interventions (patients expectations of health care...for example if they would never consider bypass surgery, why perform an angiogram...) etc.

Note: These two processes are usually integrated together.

2. Re: _____

This is usually a secondary active problem which may be relevant but is not the chief complaint. It takes on its most important role with patients with multiple significant medical illnesses or in a clinic setting.

Allergies: NKDA or list each medication and indicate type of reaction, many people say they are allergic but mean intolerant of so specify.

1. Penicillin: Anaphylaxis
2. Codeine: GI upset

Meds: List with dosages etc. "See admission orders" is not acceptable since this list is often used for patient teaching on discharge.

ROS: A Review of systems should almost always be done but rarely does much of it need to be documented. The real purpose of the ROS is to be sure you have not missed something important in your history and to help you to better understand your patient.

Past Medical History (this is one of the most important sections)

Use titles and then detail in subsections. For example

1. CAD:

- a. Anterior MI 1997 complicated by CHF
- b. Inferior MI 1998
- c. Triple CABG 1998: no chest pain since then or Class II angina since (see HPI). Etc.

Past Surgical History

- 1. _____: 1998
- 2. _____: 1997, complicated by ...

Family History:

Current Life situation (social)

In internal medicine, this can be a crucial piece of information as it helps with discharge planning etc.

Physical Exam:

Results of Investigations:

Summary:

Summarize the pertinent patient history. For example: Mr. _____ is a 65 y.o. male who presents with a history of prolonged C/P 5 days PTA with increasing SOB/OE, PND and orthopnea since. He has new ECG findings consistent with a recent MI in the septal region and his CXR is consistent with CHF. His background history is significant for stable Class II angina and poorly controlled Type II DM.

Assessment and Plan:

- 1. Main Problem:
 - a. DDX #1
 - b. DDX #2
 - c. DDX #3
- 2. Secondary Problem
- 3. Other problems that need to be monitored such as DM etc.

Example:

1. SOB, orthopnea and PND

Assessment:

- a. Worsening CHF because of medication non-compliance and anemia:
This is the most likely because. history, ...symptoms and ...physical etc.
- b. Acute MI
This is also a reasonable possibility because
- c. Pulmonary embolism
Although this is possible, it is less likely because...
- c. COPD exacerbation
I think that this is unlikely because...

Plan:

List the main points of your plan (i.e. control CHF with IV lasix, topical nitro; consider adding ACE when stable...Echo to determine underlying etiology. If evidence of underlying ischemic cause, consider...)

2. Hypokalemia

Assessment:

- a. Diuretic use
This is the most likely because...
- b. Diarrhea
Although this is possible, he is only having four BM per day and therefore it is not likely, it may be a contributor

Plan: Start K replacement and send stool for C. Diff, C& S etc.

II. How should I write my follow-up notes?

The following is meant as a guideline for deciding when to write a note and what to include in that note. You may alter the format to suit your own style as long as it contains the same type of information.

i. How often should I write a note?

- All patients do not need a full daily note. For many patients, especially those awaiting tests or with no active problems, this ends up taking up a lot of your time with little real patient benefit.

ii. Do my notes contain the right amount and type of information?

- One good trick for assessing the quality of your notes is to pretend that you don't know the patient and that you have been called to assess them for acute SOB. Can you use the most recent notes to understand what has been going on and the team's plans for this patient?

iii. The Thorough note:

This format should be used for the following situations:

- Picking up a patient for the first time.
- When you have not seen them for a few days (i.e. on the Monday if you were not on call all weekend).
- Prior to the weekend when you are not on call that weekend.
- When there is a change in your patient's medical status (i.e. deterioration, new problem etc.)

Format:

Start off with a brief summary of the patient's stay so far, followed by a list of the active medical problems. Then, for each active problem, do a separate SOAP style note.

For example:

Mr /Mrs _____ is a ___ y.o who was admitted ___ days ago with _____ (chief complaint) which we have since diagnosed as _____. His/her stay has been complicated by _____.

His/her active problem list includes:

- 1.
- 2.
- 3.

Re: "title for problem #1"

Subjective: This essentially is the follow-up history with regards to this problem. If the problem is CHF, it relates to orthopnea, PND, SOB, SOBOE etc.

Re: "title for problem #2"

Subjective: "

Objective: This refers to your pertinent physical and investigations. It is best to combine these into one section rather than by problem.

Assessment and Plan:

Again, separate these by problem title

Problem #1 Assessment: Has the diagnosis or ddx. changed? How well are we managing this problem?

Problem #1 Plan: What is the ongoing plan for this problem?

iv. Problem specific follow-up note

This one is easy. Start off with a statement like. See note dated _____ for full details. Then, state the problem you will be addressing (Re: _____) with this note and use the SOAP format to write the note.

III. Special Circumstances (DNR orders and procedure notes)

i. Goals of Care Orders:

- All goals of care orders (e.g., DNR) should be reviewed with the senior resident and or attending on the team.
- The type of discussion and the people involved in the discussion needs to be well documented in the chart.

ii. Procedure Notes:

- All procedures need to be documented in the chart.
- The note should include what procedure was performed, indications for the procedure, what discussion was had with the patient and/or their family prior to the procedure (consent), who performed it, and how was it performed, who supervised it and the preliminary findings.
- If the procedure was attempted unsuccessfully, this also needs to be documented.

IV. Addendum

For all of these, don't forget:

- Always sign your note.
- Always document the date and time of your note.
- Consider putting your pager number next to your signature.
- Remember the person on call...make it legible!
- Consider getting info from outside sources (i.e. call F.D. or specialists involved in patients care in the community etc.)

Medicine - Discharge Planning and the D/C Note

D/C Checklist

Discharge planning begins at the time of admission. However, if not already done, don't forget to do the following:

1. Day before D/C

- Contact patient's family doctor and/or pertinent specialists (if relevant).
- Fill out forms:
 - Inpatient/One day stay face sheet (see p 4)
 - Discharge summary sheet (see p 4)

- Write out scripts as follows:
 - No change to their prior medication regimen - write out scripts only for new meds.
 - Multiple changes to prior meds- write out a script indicating all meds that the patient is to take on discharge.*Don't forget to use the **limited use codes** when required.
 - **If pre-hospitalization meds have been changed or stopped, indicate these on the scripts as well** (i.e. D/C Metformin, ↑Lasix 80 mg Bid etc.)
 - Don't order PRN meds unless truly indicated.

* You can also ask the ward pharmacist to review these with the patient prior to D/C

- Discuss D/C plans with patient and/or their families:
 - What happened in hospital
 - Changes in meds
 - What to expect
 - Complications to watch for and what to do if they occur

- Inform/arrange for home care (CCAC) etc. when appropriate.

2. Day of D/C

- Do any tasks not already done.
- Review **scripts** with senior.
- Ensure that appropriate **follow-up** has been arranged and that the patient is aware of these plans.
- Dictate** the D/C summary and *indicate that you have done so*
 - Must be done within 24- 48 hours of D/C
 - Any patient who will need to be seen within the next 3-4 weeks should be dictated as a **STAT** (i.e. press 6 at anytime while dictating the note).

Note: Patients who have **died** also need a discharge summary! If you are on call when this occurs, and you are not just cross-covering, as a courtesy to your team mates, please dictate the summary (the charts are often difficult to track down afterwards). If not, let the team senior know the next morning so they can ensure that it gets done.

Dictation

1. Prior to Dictating:

- Be sure that you are clear on the discharge plans for the patient (you may need to discuss these with the senior prior to dictating your note).
- Make a list of all the names (first[†] and last) of physicians who should receive a copy of this note (attending, family physician, any specialists who were involved in their care while they were in hospital or who follow them on an outpatient basis).
- Find a quiet place to dictate
- Remind yourself to "speak slowly" and spell key words (esp. physician last names, drug names and doses etc.)

† For transcription services to mail/fax it out, you need at least a first initial. If you have a fax number as well, include it in the dictation. This is especially important for out of town physicians. For these, you may even want to indicate in what city they practice.

2. Starting your dictation

Identify self, role, date, patient name, PIN # and their D.O.B.:

“this is John Smith PGY1 dictating for Dr. M. Goldszmidt on April 1st 2010. This is a dictation on Mr. John Doe, PIN # 1234567, DOB 05/01/69)”

Identify all physicians who should receive a copy of the D/C summary. Be sure to include their **first name/initial as well as their last name!**

Also indicate:

Date of Admission:

Date of Discharge:

3. Dictation Format[‡]

I. Most Responsible Diagnosis

II. Patient Identification

Mr. Doe is a 66 y.o. who was admitted from home where he lives with his wife...His active problem list includes:

III. Active Problems list

(1) CAD with CHF (2) Acute on Chronic renal failure (3) Type II DM etc.)

Note: This is not all past medical problems, only active ones. It may include social issues such as inability to cope and **complications arising in hospital** etc.

IV. Other Past Medical/Surgical History

Some of their medical problems may not be relevant for the current admission but should be included in list form for documentation sake.

‡ When dictating the first heading, indicate that you wish them to pull all headings in “ALL CAPS”. Also, say “new heading” for each new section.

V. RE _____

(A.k.a. History of Active Problems dealt with in hospital) For this series of sections, start with most important active problem (usually same as “Most Responsible Diagnosis” Be sure to dictate new headings for each one:

New paragraph “RE: CHF” new line...

Try to keep paragraphs relatively brief (i.e. 3-5 sentences/paragraph).

For each **Active Problem** be sure to include:

- Synopsis of original presentation including only pertinent +ves and –ves from the history, physical and investigations. (**Complete history and physical does not belong here!**)
- Course in hospital for that problem **including functional status** and pertinent **physical findings** at time of D/C. Also include results of any consultations or relevant results (labs, echo, CT, PFT etc.).
- **Note:** For 2^o problems, this may be brief

VI. Summary of Investigations (optional)§

§ Only for key ones like CT, endoscopy etc.

VII. Discharge Meds:

Goal is to have one list of meds that clarifies how they have changed since admission. It should only include Prn’s that they will be using at home:

1. *Metoprolol 25 mg bid (↑ from 12.5 mg bid)*
2. *Lasix 20 mg bid (↓ from 40 mg bid)*
3. *Plavix 75mg OD (new) ...*

In addition, lisinopril and celebrex were D/C’d

Note:

Do not include a separate list of admission meds. Do mention drug allergies (including the reaction type).

VIII. Recommendations & Follow-up:

This is the most important section so take your time here. For each problem, give it its own section and go in the same order you used above.

1. RE DM:
2. RE CHF:

For each, be sure to clarify:

- What the problem is:
 - Diagnosis, severity and prognosis (if relevant)

 - Plans for managing problem:
 - o Current therapies
 - Planned therapies
 - Planned/Pending investigations
 - What has been discussed with the patient/family (Goals of Care, resuming activities, lifestyle changes, monitoring issues (sugars, daily weights etc.) and prognosis (when relevant!))
 - Who will provide follow-up, what they will be doing and why for example:
“Because of the risk of hyperkalemia and worsening renal dysfunction, we have asked the family doctor to **re-check electrolytes in two weeks**”**
- ** For things you expect others to do, ask the transcriptionist to “**Bold that**”

Also be sure to indicate:

- o Disposition (nursing home etc.)
- o Services arranged (CCAC etc.)

Abbreviated Dictation Format

Introduction: Identify self, role, date, patient name, PIN # and their D.O.B.

Copies to: Chart, Family physician, other specialists (first and last names)

DATE OF ADMISSION:

DATE OF DISCHARGE:

I. MOST RESPONSIBLE DIAGNOSIS:

II. I.D.: Mr. Doe is a

III. ACTIVE PROBLEMS LIST:

1. _____
2. _____ etc.

IV. OTHER PAST MED/SURGICAL HISTORY

V. RE: “TITLE FOR ACTIVE PROBLEM #1”

(Include abbreviated HPIs, course in hospital and functional status at time of D/C for each active problem)

RE: “Title Active problem #1”

RE: “Title Active problem #2” etc.

VI. SUMMARY OF INVESTIGATIONS

VII. MEDS AT TIME D/C & ALLERGIES

VIII. RECOMMENDATIONS & FOLLOW-UP

- Dictate by problem (1. *Re Diabetes:*)
- State final opinion of what problem is
- Plans for managing problem:
 - Current/Planned therapies
 - Planned/Pending investigations
 - What patient/family have been told
 - Who will provide follow-up and what they will be doing

Also indicate:

- Disposition (nursing home, home etc.)
- Services Arranged (home care etc.)

Gynaecology – New Consult
LONDON HEALTH SCIENCES CENTRE

VICTORIA HOSPITAL

Surname, Given Name
PIN: 1234 56 78
DOB: 1958/05/31
Copy for: Dr. Akhtar, Saima

CONSULTATION

cc: Dr. Saima Akhtar, VH

1234 56 78

Dr. J. Smith, London

DATE OF CONSULTATION: April 21, 2010

PATIENT LOCATION: W-5AGYN-N

Dear Dr. Smith:

Given Name was seen in the 5A Clinic today regarding her concerns with dyspareunia and her overactive bladder. She is a 51-year old, nulliparous patient who has been postmenopausal for 2 years. She has not been on any hormone replacement therapy and has never had any postmenopausal bleeding. She has a history of dyspareunia or difficulty with intercourse dating back 10 years and at one point saw Dr. Chernick about low desire, but really she and her husband have very infrequent intercourse. The last time they attempted was about a year ago. She said it felt like there was a blockage near the opening and they were not able to complete it. Her husband is still very understanding and they have a good relationship. She had an ultrasound in February 2010 that really showed no abnormalities aside from a query Bartholin's cyst in the anterior vaginal wall measuring 15 mm. The right ovary was not visualized, but there were no masses, and the uterus and left ovary appeared normal. The blood work that you sent along was also normal, including a TSH at 4.92 and hemoglobin of 138. Urinalysis was also normal.

The second problem that Given Name presents with is an overactive bladder. She complains of urgency and frequency. There is no urinary incontinence, but she feels like she is unable to completely empty her bladder. There is no dysuria or nocturia. She was seen by a urologist 5 years ago and was placed on Detrol 4 mg daily. It may have made a difference, but she is not sure that it completely alleviated her symptoms. She has some constipation in terms of her bowels. She only drinks one cup of coffee in the morning and one in the afternoon and not a lot of fluids in between.

In terms of her past history, she is really fairly healthy aside from the bladder symptoms and hypothyroidism. She had an appendectomy in the past. Her Pap smears have been normal, the last one being in the summer of 2009. Her medications include the Detrol 4 mg and Eltroxin. She has no known allergies. She is smoker of ½ to ¾ pack a day for 30 years.

Family history is significant for an aunt with lung cancer.

On examination today, the blood pressure was 144/91. Heart sounds were normal. Lungs were clear to auscultation. The abdomen was soft and non-tender with no masses, and this was a very slim 51-year old patient. On pelvic examination, the vulva and vagina appeared atrophic, and there was a small, whitish lesion just under the urethra. That lesion, that she was told was a skin tag on the mons to the left, actually looks like an HPV lesion, and she said that you were actually going to remove that. With a speculum in place, the cervix was visualized, well supported, small, and nulliparous, and there was really very mild and non-significant prolapsed of the high anterior and posterior vaginal walls. Bimanual revealed a small, mid position uterus and the adnexa were clear and nontender.

I have explained to Given Name that likely the lack of use combined with postmenopausal status has led to some increasing difficulty with intercourse, but there was certainly nothing on exam that seemed abnormal aside from the atrophy. We briefly discussed the use of hormone replacement therapy, and Given Name was not interested in that, so she is going to try to have more frequent intercourse with lubricant.

In terms of her bladder, I discussed newer medications that are available, and I gave her a month worth of samples of VESicare (solifenacin) to try, and she is going to let me know how that works for her.

Thank you very much for your referral and I trust this is satisfactory.

Sincerely,

Saima Akhtar, MD, FRCSC

Department of Obstetrics & Gynecology

D: April 21, 2010 T: April 23, 2010

SA/bb Job No: 2634965/1776188

Akhtar, Saima MD, FRCSC Signed on: 2010/05/03 17:26
Akhtar, Saima MD, FRCSC Authenticated on: 2010/05/03 17:28

Gynaecology – Discharge Summary

Sample: Discharge Summary (Gynecology)

Discharge Summary

Surname, Given Name – 1234 56 78

* Preliminary Report *

Result type: Discharge Summary

Result date: April 30, 2010

Result status: transcribed

Result Title: DISCHARGE SUMMARY

Performed by: Jones, Jane on May 4, 2010 16:38

Encounter info: 416087960, LHSC-VC, Inpatient 2010/04/30

*** Preliminary Report ***

DISCHARGE SUMMARY (Unverified)

cc: Dr. Ron N. Robins, VH

1234 56 78

Dr. Saima Akhtar, VH

Dr. John Smith, Wyoming

PATIENT LOCATION: V-D41

DATE OF ADMISSION: April 28, 2010

DATE OF DISCHARGE: April 30, 2010

PROCEDURES IN HOSPITAL: Total abdominal hysterectomy and left salpingo-oophorectomy on April 28, 2010.

HISTORY OF PRESENTING ILLNESS: Given Name is a 48-year old female who was seen in consultation with Dr. Robins for menorrhagia. She has been having significant problems with vaginal bleeding over the last several months and this has required repeated transfusions. Her pre-op hemoglobin was 90. After discussion of her options, it was decided to proceed with surgical management. Therefore, she was brought to the operating room on April 28, 2010 for a total abdominal hysterectomy. Secondary to bleeding in the left adnexa. She also had a left salpingo-oophorectomy. She tolerated the procedure well. For full details, please see the dictated operative note.

COURSE IN HOSPITAL: Given Name has done quite well in hospital. By postoperative day # 2 she was feeling well and her pain was well controlled with Tylenol No. 3. She was eating and drinking well with no nausea or vomiting. She was voiding well and had passed gas, but had not yet had a bowel movement. She had minimal vaginal bleeding.

Given Name's hemoglobin on postoperative day # 1 had fallen to 70. She was asymptomatic at this point with no shortness of breath, chest pain or palpitations. However, due to her significant anemia and repeated previous transfusions, we did recommend that she again have a blood transfusion. She received 2 units of packed red blood cells on postoperative day # 1. Her post transfusion hemoglobin had risen nicely to 91.

When it was repeated again on postoperative day # 2, her hemoglobin was again stable at 91.

Her vital signs were stable throughout her course in hospital. At the time of discharge, her abdomen was soft and non-tender and her incision was clean and dry with no signs of surrounding erythema or bruising.

DISCHARGE PLANS: Given Name is to be discharged home on postoperative day # 2. Her postoperative stay was complicated by anemia requiring a blood transfusion. She has been given a prescription for Tylenol No. 3 and Colace to go home.

She will continue with her ferrous gluconate supplementation that she had already been doing at home. She will see Dr. Robins in 6 weeks' time for her postoperative appointment. We have asked her to seek medical attention if she is having any significant increase in her pain, bleeding or has a fever.

It was a pleasure taking care of Given Name in hospital and we wish her the best in follow up.

Jane Jones, MD

Resident for Dr. R. Robins

D: April 30, 2010 T: May 4, 2010

JJ/bb Job No. 1693856/1573390

Completed Action List:

* transcribed by Scott, Linda on May 4, 2010 16:28

* Perform by Jane Jones on May 4, 2010 16:38

Obstetrics – New Consult
ST JOSEPH'S HEALTH CARE LONDON

ST JOSEPH'S HOSPITAL

Surname, Given Name
PIN: J1248003

DOB: 1980/11/01
Copy for: Dr. Akhtar, Saima

OB/GYN CLINIC NOTE

cc: Dr. Tracey Crumley, SJHC
Dr. Saima Akhtar, VH
Dr. J. Smith, London
OB Triage, SJHC

DATE OF VISIT: April 21, 2010

PATIENT LOCATION: J-OB

Dear Dr. Smith:

I saw Given Name today in the Obstetrical Outpatient Clinic. As you know she is a 30-year old female in her first pregnancy. She reports a last menstrual period date of September 24, 2009 with regular cycles giving her an estimated due date of July 1, 2010. That was confirmed by ultrasound on November 17th at 7 weeks and 5 days, again on December 14th and January 27th both of which demonstrated normal anatomy, no placenta previa. She is currently 30 weeks and 6 days gestation.

Her pregnancy thus far has been associated with some nausea and vomiting through the first trimester but that has resolved. She is a non-smoker and no drugs or alcohol. She has a well balanced diet including prenatal vitamins and milk products. She has no known drug allergies.

Her past medical history is significant for wisdom teeth extraction in 1997 and diagnosis of PCOS in 2009. She required three cycles of Clomid to achieve this conception and has had no other difficulties or symptomology.

Her genetic and family risk factors are negative. Her infectious disease risks are negative. Her social supports are good.

Her antenatal labs indicate that she is rubella immune and hepatitis B negative. I do not seem to have her VDRL or HIV status, but would appreciate if those were available. Her blood group is O positive with a negative antibody screen. Her screening hemoglobin is 121 with normal MCV. 1 hour glucose was normal at 4.9.

On examination her blood pressure is 111/73. Her weight is 166 lb. Her urine is negative for protein and glucose and her symphysis fundus height is advanced at 34 cm. Vertex is presenting, fetal heart was auscultated in the 130s. She reports good fetal movement, no bleeding, leaking or contracting.

I reviewed the plan of care with her including the visit schedule and call system. I would be happy to alternate visits with you so she will see you in 2 weeks and return to see us in 4 weeks. Because she is measuring ahead, I will organize an ultrasound for her when she returns in 4 weeks. I will keep you up to date of any further developments.

Thanks for involving me in her care.

Sincerely,

Tracey Crumley, MD, FRCSC
Department of Obstetrics & Gynecology
D: April 28, 2010 T: May 3, 2010
TC/bb Job No: 2637565/1596188

Crumley, Tracey, MD, FRCSC Signed on: 2010/05/03 09:08

Crumley, Tracey, MD, FRCSC Authenticated on: 2010/05/03 09:08

TC

dd: 2010/05/03 08:15

cc: Smith, Jane MD

Akhtar, Saima, MD FRCSC
SJHC, Triage OB

Obstetrics – Discharge Summary

Discharge Summary

Surname, Given Name – 1234 56 78

* Final Report *

Result type: Discharge Summary

Result date: April 27, 2010

Result status: Auth (verified)

Result Title: DISCHARGE SUMMARY

Performed by: Jones, Jane on May 3, 2010 21:43

Verified by: Jones, Jane on May 4, 2010 09:24

Encounter info: 416087960, LHSC-VC, Inpatient 2010/04/30

*** Final Report ***

DISCHARGE SUMMARY (Verified)

cc: Dr. Ann K. Usher, VH

1234 56 78

Dr. Saima Akhtar, VH

Dr. John Smith, London

PATIENT LOCATION: V-D44

DATE OF ADMISSION: April 27, 2010

DATE OF DISCHARGE: April 30, 2010

DISCHARGE DIAGNOSIS:

1. Parturition
2. Abnormal fetal heart rate tracing (prolonged fetal bradycardia)

PROCEDURES IN HOSPITAL: Low segment caesarean section.

DATE OF PROCEDURE: April 27, 2010

DISCHARGE SUMMARY: Given Name is a 29-year old GTPAL 3-2-0-0-2 who was admitted to Victoria Hospital Family Birthing Centre on April 27, 2010 at 40 weeks and 3 days gestation based on an estimated date of delivery of April 24, 2010. She was a planned admission for post dates and did receive Cervidil the night prior. She presented in spontaneous labour. This was otherwise an uncomplicated pregnancy with no evidence of gestational hypertension or gestational diabetes. Her blood type is A+, she is GBS negative and Rubella non-immune. Her past obstetrical history includes 2 previous term vaginal deliveries in 1997 and 2006. She is otherwise healthy.

Her medications include prenatal vitamins. She has no known drug allergies.

Given Name did progress up to 6 cm dilation; however, after receiving her epidural (which turned out to be a spinal) there was prolonged fetal bradycardia down to the 60's to 70's bpm. The decision was made to go ahead with a primary low segment caesarian section for prolonged fetal bradycardia. The details are further outlined in the operative note dictated by Dr. Usher.

COURSE IN HOSPITAL: Postoperatively, Given Name did very well. Her pain was well controlled on oral analgesia. She was ambulating and voiding well without difficulty. She was passing flatus but did not yet have a bowel movement. She was tolerating a regular diet with no nausea or vomiting. She was having minimal vaginal bleeding. Throughout her stay here, she was afebrile and her vital signs were stable. The abdomen was soft and the incision appeared to be healing well with no signs of infection. Her postoperative hemoglobin was 88. She was therefore started on ferrous gluconate 300 mg p.o. t.i.d. while in hospital.

DISCHARGE SUMMARY AND PLAN: In summary, Given Name was discharged home on postoperative day 3 in stable condition. She was sent home with a script for the following medications including: Tylenol No. 3, ibuprofen, ferrous gluconate 300 mg p.o. t.i.d. and Colace 100 mg p.o. b.i.d. p.r.n. We have instructed her to seek medical attention should she have any fevers/chills, increased abdominal pain or any concerns regarding the incision site. She is to follow up with Dr. Usher in 6 weeks time for her postpartum visit.

Jane Jones, MD

Resident for Dr. A. K. Usher

D: April 30, 2010 T: May 3, 2010

JJ/bb Job No. 1692056/1573380

Signature Line

Jones, Jane, MD Signed on: 2010/05/04 09:24

Jones, Jane, MD Authenticated on: 2010/05/04 09:24

Usher, Ann, MD FRCSC
dd: 2010/05/03 21:43 dt: 2010/05/03 21:32
cc: Akhtar, Saima MD, FRCEC
Nizami, Tariq, MD, CCFP

Completed Action List:

- * transcribed by Scott, Linda on May 3, 2010 21:32
- * Perform by Jones, Jane on May 3, 2010 21:43
- * Sign by Jones, Jane on May 4, 2010 09:24
- * VERIFY by Jones, Jane on May 4, 2010 09:24
- * Review by Nizami, Tariq on May 5, 2010 12:21